WASHINGTON STATE IMMUNIZATION PROGRAM CHILD PROFILE

IMMUNIZATION UPDATE

SPRING 2006

INSIDE THIS ISSUE:

WORKING TOGETHER–IMMUNIZATION HIGHLIGHTS AND UNIVERSAL UPDATES FROM THE PROGRAM MANAGER

The 2006 legislative session was very busy for the Immunization Program CHILD Profile and it is exciting to share that our state Legislature provided the funding we requested for our universal vaccine system.

This funding assures we will continue to provide recommended vaccines to all of Washington's children ages birth through 18 years. With this funding, the adolescent meningococcal and pertussis vaccines will be available starting July 1, 2006.

Additionally, the Legislature provided a specific allocation for purchasing some of the newer combination vaccines that the program has been unable to purchase in the past. We are starting to develop the process to determine which combination vaccines to purchase in accordance with the guidelines the Legislature provided. We should be able to start purchasing some of the newer combination vaccines in early October 2006.

Just as we successfully cleared this hurdle, the new rotavirus vaccine received an Advisory Committee on Immunization Practice (ACIP) recommendation; restarting our process for seeking state funds to maintain our universal vaccine system. At this point in time, we anticipate

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ROUTINE CHILDHOOD IMMUNIZATIONS SAVE BILLIONS EACH YEAR

A recent study by CDC's National Immunization Program evaluated the impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule. The study concluded that vaccines are tremendously cost effective. This is the first time the seven vaccines have been examined together and with a common methodology.

The study found that use of these seven vaccines will prevent over 14 million cases of disease and over 33,500 deaths over the lifetime of children born this year. When comparing the cost of the diseases they prevent and the cost of administering them, these vaccines save nearly $10 billion per year. These vaccines also prevent the need for patients to spend time seeking care and the need for parents to take time off work to care for sick children. When including these and other prevented costs to society, the annual savings exceed $40 billion.

A child is protected from vaccine-preventable diseases after receiving a series of vaccines over time, not just one shot. Therefore, this economic evaluation is groundbreaking because previous studies on the cost savings of childhood vaccination in the United States only focused on single vaccines. This provides a more complete picture of the economic impact of vaccines. Administrators and policy makers can use the results to justify sustained support for programs, make needed modifications, and guide future programs.

The publication, "Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the United States, 2001," appears in the December 2005 edition of *Archives of Pediatrics and Adolescent Medicine.* For a summary go to: http://archpedi.ama-assn.org/cgi/content/short/159/12/1136.

Washington State Department of Health

VACCINE MANAGEMENT BUSINESS IMPROVEMENT PROJECT UPDATE

Background

The Vaccine Management Business Improvement Project (VMBIP) will result in the direct shipment of vaccines from a third party distributor to providers. State and local health jurisdictions (LHJs) will continue to be the gateway to providers for participation in the childhood vaccine program, and will retain their roles and activities related to processing provider orders and quality assurance. The Immunization Program CHILD Profile and LHJs worked hard on the planning for VMBIP through the early fall 2005. After a short break from this planning to respond to the flu season, the program is again gearing up for implementation in late fall 2006.

Update

CDC is delayed in processing the national contracts needed to begin VMBIP and estimates the target start dates for the project will be sometime in **September or October 2006.** The delay allows time for training and follow-up with LHJs this spring; and for provider training throughout the summer. The delay also allows for maintaining the existing system through the back-to-school rush, one of the busiest times for vaccine distribution.

The program is strategizing with CDC to scale down state and local vaccine inventories, and discontinue distribution activities at the state and local level. The goal is simple—thoughtful implementation that assures the vaccine supply and provides a safety net during the transition to third party distribution.

Regional training

To support the successful transition and implementation of VMBIP, a joint Department of Health/LHJ committee is planning regional training sessions in April and May 2006 for LHJ staff. The VMBIP training is being paired with AFIX/Co-CASA training in order to efficiently address two key priorities for public health immunization. The training is a train-the-trainer model for local health participants, and will include a focus on training tools, communicating, and working with providers. Given the importance of these topics and the level of detail that will be covered, the training will be 2 days—one for VMBIP and one for AFIX/Co-CASA.

Training details

The department will provide travel support to LHJ participants and the training will be held in four sites throughout the state to minimize travel time and costs. LHJ Immunization Coordinators are assisting with the training development.

Dates and locations are listed below. RSVPs will be accepted by fax at 360-236-3597, attention Flo Zikas.

Spokane at the Community Colleges of Spokane BCT: **April 18 and 19.**

Olympia at the Department of Health: **April 26 and 27.**

Moses Lake at Big Bend Community College: **May 3 and 4.**

Shoreline at Shoreline Community College: **May 10 and 11.**

For more information, please contact Jan Hicks-Thomson at 360-236-3578 or Jan.Hicks-Thomson@doh.wa.gov.

THIRD PARTY DISTRIBUTION IN WASHINGTON STATE—WHAT DOES IT MEAN?

What is happening now?

Washington currently maintains a central vaccine distribution depot, holding about $6 million in vaccine inventory, and distributing about $3 million in inventory every month. In turn, 35 local health jurisdictions (LHJs) maintain a high volume of vaccine inventory for distribution to over 1100 provider sites.

Single dose syringe packaging, high-volume distribution timeperiods, and an increasing number of vaccines, are creating pressure on storage capacity. There are three or four links in the cold chain between the manufacturer and the provider. Each time vaccine is repacked and shipped, it creates an opportunity for vaccine loss, and each depot poses a risk for a high volume of vaccine loss. There have been several large losses at the LHJ depot level over the last few years. LHJ staff must be on-call for late night alarms if their refrigerator system malfunctions.

What's next?

Third party distribution means that vaccine is shipped directly to providers. King County has already converted to third party distribution. This process will be similar to when Washington implements third party vaccine distribution through the Vaccine Management Business Improvement Project.

Public Health—Seattle & King County transitions to third party distribution

Because of storage and handling as well as staffing and cold chain issues, Public Health—Seattle & King County (PHSKC) started third party distribution about 9 years ago. General Injectibles and Vaccines (GIV) is a third party distributor located in Virginia. PHSKC uses GIV for vaccine storage, packing, and overnight shipping directly to providers. Providers have been happy with direct delivery, and PHSKC no longer has to worry about storage and handling.

There is less concern about liability for storage and fewer opportunities for cold chain mishaps. PHSKC uses a broadcast fax system and a newsletter to communicate with providers. It has also freed up staff time to conduct quality assurance and tracking activities.

How will ordering work with third party distribution?

Providers will submit all vaccine orders to LHJs for approval prior to processing. Providers can order vaccines via mail or fax. Providers are encouraged to order once per month, and emergency orders can be filled if necessary.

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IMMUNIZATION PROGRAM CHILD PROFILE STAFF CHANGES

IPCP has undergone a significant reorganization over the past 18 months. The following is an update of recent changes:

New to IPCP

Nicole Avelar, Secretary Senior

Michelle Bilhimer, Research Assistant

Vicki Bouvier, Policy and Planning Coordinator

Sonja Dordal, Health Educator

Gary Gant, Quality Assurance Coordinator

Colin Helsley, Vaccine Consultant

Lonnie Peterson, Health Educator

Molly Robertson, Special Projects

Debbie Spink, Special Projects

Louise Taylor, Special Projects

Pam Walker, Health Educator

Promotions

Karen Arbogast, Clinical and Quality Assurance Unit Manager

Tawney Harper, Program Administration Unit Manager

Nicole Pender, Adult and Adolescent Coordinator

Michele Perrin, Health Promotion and Communications Unit Manager

Left IPCP

Ruth Francis-Williams, Tom Kimzey, and Carlos Quintanilla.

Below is an updated IPCP organizational chart, which includes names, titles, and phone numbers.

WELCOME CHAS DEBOLT, VACCINE PREVENTABLE DISEASE EPIDEMIOLOGIST

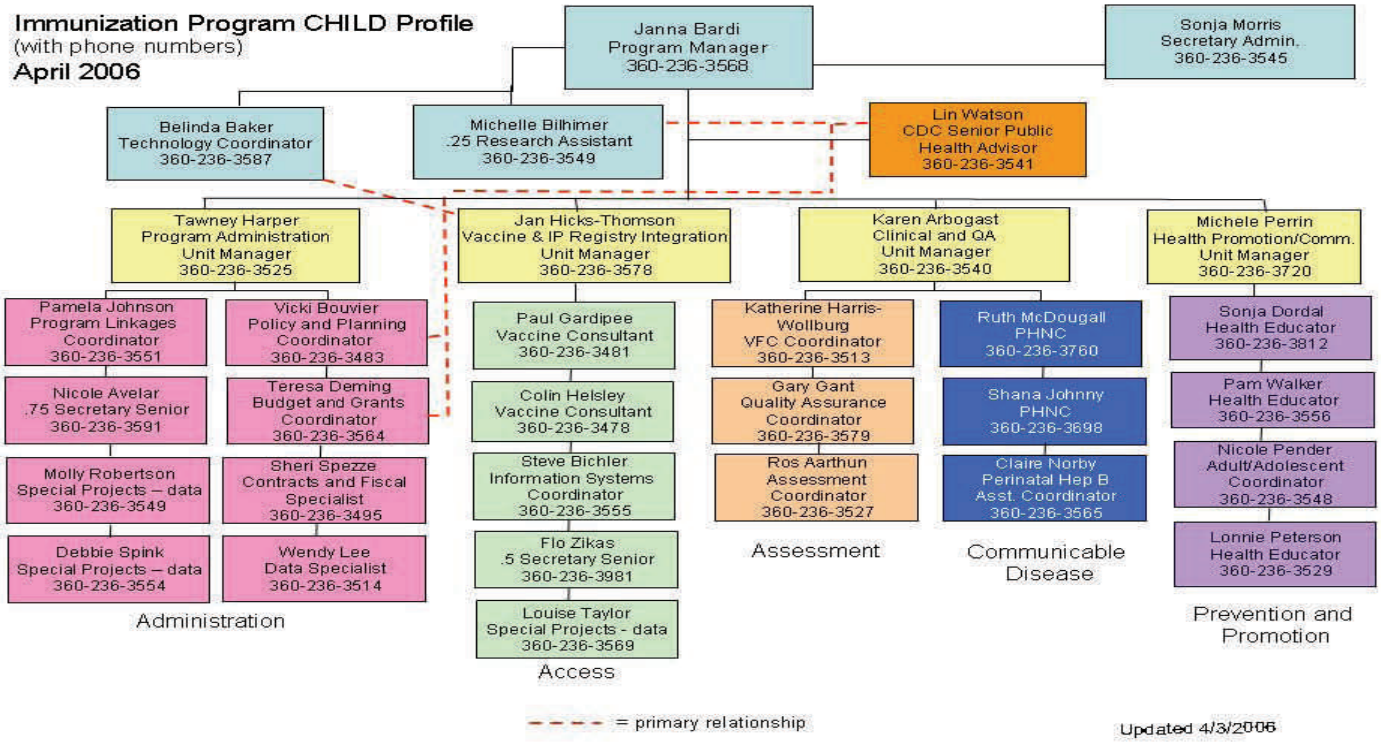
The Department of Health Communicable Disease Epidemiology (Epi) section is pleased to announce a recent addition to its staff. Chas DeBolt is the new Vaccine Preventable Disease Epidemiologist. Chas, who has considerable experience in local public health in Washington, is trained in nursing and public health and worked for many years on the investigation and control of vaccine preventable diseases.

Her experience will be a valuable asset to the department and will enhance its ability to focus on improvements in the approach to vaccine preventable diseases.

This change was a collaborative effort between the Immunization Program CHILD Profile (IPCP) and Communicable Disease Epi to consolidate the investigation and surveillance of acute vaccine preventable diseases to a single office at the state level. Requests for assistance or information regarding surveillance or investigation of acute vaccine preventable diseases should be directed to Chas, including rash illnesses formerly investigated by IPCP.

The acute vaccine preventable diseases that are notifiable include diphtheria, invasive *Haemophilus influenzae* infections in children aged <5 years, hepatitis A, acute hepatitis B, measles, meningococcal disease, mumps, pertussis, polio, rubella, and tetanus.

Chas can be contacted at 206-418-5431 or chas.debolt@doh.wa.gov.



IMMUNIZATION REGISTRY CONNECTIONS

The disaster surrounding Hurricane Katrina led to unprecedented sharing of immunization information between systems around the country.

Within days of the hurricane, public health and health care providers in Washington State were able to use the CHILD Profile Immunization Registry to query the Louisiana immunization registry (LINKS).

This HIPAA-compliant link enabled providers to check the immunization status of displaced people. Public health and health care providers can also access Mississippi and Alabama's Immunization Registries by contacting the CHILD Profile Help Desk staff at 1-800-325-5599, who will then query the registry on their behalf and retrieve immunization status information for people from either of those states.

This link made a big difference. A nurse from Harborview Children and Teens Clinic called regarding two children from Louisiana. The nurse was able to use the CHILD Profile Immunization Registry communication link to access the data in the Louisiana system for one of the children, while a CHILD Profile staff member accessed the other child's data. The nurse was "thrilled with the process." Sharing of immunization data between registries is a valuable tool that enables providers to have the data they need in order to provide the most appropriate immunizations and avoid giving unnecessary immunizations.

IMMUNIZATION DATA EXCHANGE WITH IDAHO

The CHILD Profile Immunization Registry opened a link with the Idaho Immunization Registry (IRIS) on October 26, 2005. Similar to the communication link with the Louisiana registry, public health and health care providers in Washington will be able to use the Registry's communication link to query IRIS. Idaho providers will use the same link to query the Washington Registry. This link will enable providers to check the immunization status of residents who cross the border for health care or who have moved from one state to another. Utilizing this data exchange link will help improve immunization services, especially for those living in border communities.

CHILD PROFILE UPDATE

Health and safety mailings

CHILD Profile Health Promotion mailings are sent to 86 percent of Washington parents of children aged birth to 6 years. Evaluation data shows that parents find the mailings useful, and the information helps them get their children immunized on time.

Materials are available in English and Spanish, and participating clinics and providers can select Spanish for patients they know would prefer it. Samples of the materials can be seen at www.childprofile.org and quantities of certain materials are free to providers who participate in the Immunization Registry. If you have patients who are not receiving the mailings, you can call CHILD Profile with that information or have the patient call 1-800-322-2588 to sign up.

Immunization focus groups

In November and December 2005, a series of five focus groups regarding immunizations were held with first-time parents of children under the age of 1 year. The goal was to gather information on how to improve and/or enhance the immunization information parents receive in CHILD Profile mailings. The groups were held in Seattle, Mount Vernon, Olympia, and Kennewick. A final report will be available soon.

Parent satisfaction survey

In summer 2005, the CHILD Profile Parent Satisfaction Survey was conducted of parents receiving CHILD Profile materials. Five different surveys were developed to evaluate specific mailings, including the 6-month, 1-year, 2-year, 4-year, and 6-year mailings. All surveys were translated into Spanish.

Statewide, 7142 surveys were mailed. Response rates varied by survey and averaged 38 percent as of November 2005. Overall, survey results show that respondents find the materials useful, easy-to-read, and appropriate. Results from the 2005 surveys will include detailed information evaluating partnership materials and more specific knowledge and behavior changes from CHILD Profile mailings. Results will be available later this year.

New 3–5 year Development Chart

An exciting new partnership will allow for the expansion of the Development Charts to include a new chart covering the ages of 3–5 years. Partners in this effort are the Bill and Melinda Gates Foundation, the Kirlin Foundation, the Foundation for Early Learning, Talaris Research Institute, and the Office of Superintendent of Public Instruction. This partnership will also expand dissemination of the three CHILD Profile Development Charts to non-parental caregivers, such as pediatricians and child care providers.

View the recently revised chart covering children aged birth to 18 months at: www.childprofile.org/hpmats/chartBirth_18mo.pdf.

For more information, please contact Denise Farrand, CHILD Profile Health Promotion Operations Manager, at 206-296-2788 or denise.farrand@metrokc.gov.

Spotlight on Local Health

CLALLAM COUNTY'S WIC IMMUNIZATION SCREENING PROJECT

In July 2003 when the WIC program initiated the practice of checking DTaP vaccinations for enrolled children aged 24 months and younger, Clallam County decided to join WIC and immunization services to expand the immunization screening policy to include all vaccines and all WIC children.

The goals for the expanded immunization screening program were to collect data that would enable Clallam County to more accurately determine the percentage of children aged 18–24 months who were up-to-date on their immunizations, evaluate the need and practicality of offering immunizations during WIC clinics, provide immunization education to parents, increase the number of children aged 18–24 months whose immunizations were up-to-date, and enter all records into the CHILD Profile Immunization Registry.

The program is currently designed to evaluate and record immunization records for all WIC enrolled children. This collaboration has been successful in large part because both the WIC and Immunization staff are committed to maintaining a high level of vaccination coverage, which helps to prevent the outbreak of vaccine preventable diseases in Clallam County and protects individual children and their families.

Neither WIC nor Immunization staff feel overburdened because the assessment tasks are shared. In a nut shell, the WIC staff collect client immunization records from parents or pull a previously completed Immunization Survey form for all WIC clients whose records are due to be reviewed. Immunization staff review records, make recommendations on the Immunization Survey form that WIC certifiers pass on to parents, send immunization reminder cards to parents if appropriate, and enter data into the Immunization Registry and CASA.

Through the sharing of success stories, both WIC and Immunization staff feel that Clallam County's efforts have resulted in significant benefits to WIC clients. A local provider's plan to delay the third dose of hepatitis B vaccine for the child of a carrier mom was identified and corrected, a number of children whose vaccinations were significantly delayed have been updated, hesitant parents have received individual counseling and educational materials, parent records have been brought up-to-date, many records have been added to the Registry database, erroneous data in the Registry has been corrected, and a CASA database was created to collect county-wide immunization data.

This is still a work in progress for Clallam County as it continues to fine-tune its collaborative procedures. The real impetus for the entire staff is the belief that this project truly practices public health. The satisfaction obtained from looking at clients as a whole, contributing to the prevention of illness, and improving health is why we come to work every day.

Thank you to Anne Johnson, Clallam County Health & Human Services, for submitting this article. Anne can be reached at 360-417-2439 or ajohnson@co.clallam.wa.us.

PUBLIC HEALTH—SEATTLE & KING COUNTY RECEIVE IMMUNIZATION AWARD

Congratulations to Public Health—Seattle & King County's (PHSKC) Immunization Program for winning a Centers for Disease Control and Prevention's award for improvement in immunization coverage by 17.4 percent among children aged 19–35 months since 2001. This is the second consecutive year that PHSKC was recognized. The award was presented during the National Immunization Conference in March in Atlanta, Georgia. Thank you for your ongoing commitment and keep up the good work!

VARICELLA IMMUNIZATION REQUIREMENT UPDATE

Information on the addition of varicella to the immunization requirement and related forms are being distributed to all public and private schools, Head Start, ECEAP programs, and licensed child care centers. The plan and all forms are available at: www.doh.wa.gov/cfh/immunize/schools.htm. Please refer callers to the Web site if they have access.

Information is also being submitted to the Washington Chapter of the American Academy of Pediatrics and the Washington Academy of Family Physicians for inclusion in their newsletters.

Please share this information broadly, including with immunization providers in your jurisdiction. Remind providers that live vaccines (MMR and varicella) not administered simultaneously should be separated by at least 4 weeks (28 days); 4-day grace does not apply. This information can be found in 9th edition of The Pink Book at: http://www.cdc.gov/nip/publications/pink/.

To spotlight your local immunization work in the next *Immunization Update* newsletter, contact Lonnie Peterson at 360-236-3529 or lonnie.peterson@doh.wa.gov. Feel free to reprint articles for your newsletters or for provider outreach.

IOWA AND MIDWEST MUMPS OUTBREAK

With 1273 reported, probable, confirmed and suspect cases of mumps in Iowa, the Iowa Department of Public Health (IDPH) and local Iowa public health agencies, with assistance from the University of Iowa Hygienic Laboratory and Centers for Disease Control and Prevention (CDC) continue to address the current mumps situation in the state.

Mumps cases are also being identified in many neighboring states.

Since the first report of mumps to IDPH, the state health department has monitored, communicated, and educated health care providers and the public about the increase in numbers of cases. Mumps resources, including twice-weekly case updates, can be viewed on IDPH's Web site at: www.idph.state.ia.us.

Due to the length of time it takes for symptoms of mumps to appear, sharing information with other states and with those states with recent mumps activity has been critical. The state has been coordinating activities with CDC. Dr. Patricia Quinlisk, state epidemiologist, continues to lead calls with other state epidemiologists and CDC officials.

For the latest information on mumps, visit http://www.idph.state.ia.us/adper/mumps.asp or http://www.cdc.gov/nip/diseases/mumps/mumps-outbreak.htm.

POLIO INFECTIONS: MINNESOTA AND ABROAD

Adapted from Morbidity and Mortality Weekly Report, October 21, 2005 and February 3, 2006.

On September 29, 2005, the Minnesota Department of Health identified poliovirus type 1 in an infant girl aged 7 months who was unvaccinated and immunocompromised. The patient lives in an Amish community that is largely unvaccinated against polio.

Three additional children from the same community tested positive for the polio virus type 1. These three children are unvaccinated siblings living in the same household (not in the same household as the index patient).

None of the people in the community that showed evidence of current or past infection with poliovirus type 1 have exhibited symptoms of paralytic disease. There is concern about Vaccine-Derived Polio Viruses (VDPV) though, because these viruses are considered able to cause paralytic disease. Hospitals that serve this community and affiliated communities are being contacted and surveyed in an attempt to identify patients whose diagnoses indicate conditions that are clinically consistent with poliovirus infection.

Poliovirus type 1 is a VDPV. VDPVs are poliovirus strains derived from one of the three parent polio virus strains in Oral Polio Vaccine (OPV). VDPVs emerge from OPV viruses as a result of: (1) their continuous replication in immunodeficient persons such as the index patient in this investigation, or (2) their circulation in populations with low vaccination coverage.

VDPVs in highly immunized populations are rare. Before the VDPV identification in Minnesota, the most recent known person excreting VDPV in the United States was a child with severe combined immunodeficiency (now deceased) who developed vaccine-associated paralytic poliomyelitis in 1995. These cases mark the first identification of VDPV in the United States since OPV was discontinued for use in 2000. The vaccine currently used in the United States is injected poliovirus (IPV). This vaccine provides immunity to poliovirus type 1. The Advisory Committee on Immunization Practice recommends that all three doses of IPV be administered on an accelerated schedule if a patient has an unknown or undocumented polio immunization history. A booster dose of IPV is recommended for susceptible adults and health care workers at high risk of exposure to the virus.

Another case of polio was identified in March 2005 in an unvaccinated woman who traveled to Central and South America. The type of polio that this patient contracted was paralytic polio. This type of polio is rare in the United States because: (1) transmission of indigenous wild poliovirus has been eliminated, and (2) imported cases of wild poliovirus have been controlled, and vaccine policy changes discontinuing the use of OPV eliminated vaccine-associated paralytic polio (VAPP) cases.

The primary risk for paralytic polio for United States residents is through travel to countries where polio remains endemic or where polio outbreaks are occurring. This case is the first *imported* VAPP case ever documented in the United States.

The patient was most likely exposed through contact with an infant recently vaccinated with OPV. Since OPV is a live, attenuated vaccine, the virus can be shed in the stool of the vaccinated person for up to 6 weeks after the vaccine is administered. This case highlights the previously unrecognized risk for paralytic polio among unvaccinated persons exposed to OPV during travel abroad.

For more information on polio, visit CDC's Web site at: http://www.cdc.gov/nip/diseases/polio/faqs.htm.

Resources

IMMUNIZATION: YOU CALL THE SHOTS MODULE 3: POLIO

CDC's National Immunization Program (NIP) released the third instructional module in the *Immunization: You Call the Shots* series of Web-based training materials.

The new module titled, "Polio," discusses polio disease, vaccine, and recommendations for vaccine use. Extra learning opportunities, self-test practice questions, reference and resource materials, and an extensive glossary, are all provided in an easy-to-use format.

Immunization: You Call the Shots is an interactive, self-study course that participants can complete at their own pace. It is intended for introductory training of health care professionals who provide immunizations and as a reference or refresher for all immunization providers.

Modules currently available in the series include "Understanding the Basics: General Recommendations on Immunization and Diphtheria, Tetanus, and Pertussis."

The series' audience includes nurses, nursing students, medical assistants, pharmacists, and other health professionals who provide immunizations. The purpose of the course is to improve immunization practice in the United States by increasing health professionals' knowledge of immunization principles, use of routinely recommended vaccines, and proper vaccine administration practices.

The free course is available on the NIP Web site at: http://www.cdc.gov/nip/ed/youcalltheshots.htm. **Free continuing education credits will be provided.**

Questions or comments about the "Polio" module may be e-mailed to nip-info@cdc.gov.

MATERIALS UPDATE

Free immunization materials are available from the Department of Health Immunization Program CHILD Profile (IPCP). Materials include everything from parent fact sheets and Vaccine Information Statements to reminder recall cards and Lifetime Immunization Record cards. Visit the Forms and Materials page on the IPCP Web site to view materials and find ordering information at: http://www.doh.wa.gov/cfh/Immunize/form_pubs.htm.

New or updated materials include:

Material	Format
2006 Certificate of Immunization Status form (English)	Online and print copies available May 2006.
2006 Certificate of Immunization Status form (Spanish)	Same as above.
Vaccines Required for Schools (2006–07)	Same as above.
Vaccines Required for Child Care (2006)	Same as above.
Lifetime Immunization Record Card	Revision in process. Available May 2006.

VACCINE STORAGE AND HANDLING TOOLKIT

An extensive toolkit on storage and handling is available from CDC's National Immunization Program. It covers everything from cold chain to vaccine preparation and disposal and is available at: http://www2a.cdc.gov/nip/isd/shtoolkit/splash.html.

NNII RESOURCE KIT FOR HEALTHCARE PROFESSIONALS

The National Network for Immunization Information's (NNii) resource kit for healthcare professionals is a comprehensive kit to help healthcare providers discuss immunization with their patients.

The kit provides accessible information on everything from immunization recommendations to common questions and concerns. All materials are the product of extensive research with parents, physicians, nurses, immunization experts, and risk communication specialists.

The resource kit is being currently updated. Please visit the section Vaccines and the Diseases they Prevent for up-to-date information about each vaccine.

Entire resource kit

The kit is available in Adobe Acrobat PDF format (you may need to download the free Acrobat Reader to view these files). Download the entire kit, each section, or specific vaccine information. Click the arrow graphic next to each section or topic you wish to download. The kit is available at: http://www.immunizationinfo.org/assets/files/pdfs/1_PEDIATRIC_FULL.pdf.

NEW CHILDHOOD HEPATITIS B ACIP STATEMENT

On December 23, 2005, the New Childhood Hepatitis B statement from the Advisory Committee on Immunization Practice (ACIP) was published in CDC's *Morbidity and Mortality Weekly Report.* This report, the first in a two-part statement, provides updated recommendations and approaches to address challenges in eliminating hepatitis B virus (HBV) transmission in the United States.

Improve prevention of perinatal and early childhood HBV transmission

Implement hospital delivery policies and procedures, case-management programs, and laws and regulations to improve identification of infants born to Hepatitis B Surface Antigen-positive (HBsAg+) mothers and to mothers with unknown HBsAg status at delivery; ensure administration of appropriate post-exposure immunoprophylaxis to these infants at birth; and administer a birth dose of hepatitis B vaccine to medically stable infants who weigh >2000g and who are born to HBsAg-negative mothers.

Improve vaccine coverage of children and adolescents who were not previously vaccinated

Implement immunization record reviews for all children aged 11–12 years and children and adolescents aged <19 years born in countries with high or intermediate HBV rates, adopt hepatitis B vaccine requirements for school entry, and vaccinate all unvaccinated adolescents in settings that provide health care services to persons in this age group.

Up to five copies of the new ACIP Childhood Hepatitis B Recommendations can be ordered for free at: http://webapp.cdc.gov/ixpress/pubsprod/hepa+book/hepa.dml. Scroll down to "Information for Health Professionals," item number H16.

CDC's Division of Viral Hepatitis' Web page has resources related to the new ACIP Childhood Hepatitis B Statement at: http://www.cdc.gov/ncidod/diseases/hepatitis/b/acip.htm.

For more information, contact Shana Johnny at 360-236-3598 or shana.johnny@doh.wa.gov.

HEPATITIS B RESOURCES

CDC's Division of Hepatitis has recently posted two new resources on their Hepatitis B Statement Web site at: http://www.cdc.gov/ncidod/diseases/hepatitis/b/acip.htm.

The "Protect your Baby for Life from Hepatitis B" birth dose brochure for parents may be accessed directly through the following link: http://www.cdc.gov/ncidod/diseases/hepatitis/b/hepbandyoubrochure.pdf. The "If you have Chronic Hepatitis B" information may be accessed at the following link: http://www.cdc.gov/ncidod/diseases/hepatitis/b/chronicBcard.pdf.

At this time there is no funding for printed copies; however, you are welcome to print copies of these resources directly from the Web site.

VACCINE INFORMATION STATEMENTS

The final version of the hepatitis A VIS has been released by CDC and is posted on the NIP Web site at: http://www.cdc.gov/nip/publications/VIS/default.htm. It is dated March 21, 2006 and has been updated to include both the 1-year minimum age and routine use among all children. The Immunization Program CHILD Profile is currently printing this version and it will be available to order from the DOH warehouse in a few weeks.

An interim VIS for rotavirus vaccine has been drafted and is going through NIP clearance and may be available in the next couple of weeks. An interim VIS for Tdap is also being drafted. It will cover vaccine use for both adolescents and adults. The IPCP will keep you updated as to when these are finalized and available.

CDC COURSE AVAILABLE ON DVD

CDC's 2006 Epidemiology & Prevention of Vaccine Preventable Diseases course will be available on DVD in spring 2006.

Each session of the 4-session broadcast is 3 1/2 hours long. The live interactive program provides the most current information available in the constantly changing field of immunizations.

Session 1

Session 1 covers principles of vaccination, general recommendations on immunizations, and vaccine storage, handling, and administration.

Session 2

Session 2 covers pertussis, pneumococcal disease (childhood), and Hib.

Session 3

Session 3 covers measles, rubella, varicella, polio, and meningococcal disease.

Session 4

Session 4 covers hepatitis A and B, influenza, and pneumococcal disease (adult).

The broadcasts also feature question-and-answer sessions. Each session can be viewed for CE credit at: www.phppo.cdc.gov/PHTN/epv06/default.asp. You can order a free copy from CDC at: http://www.cdc.gov/nip/publications/.

If you would like additional copies, please contact Sonja Dordal at 360-236-3812 or sonja.dordal@doh.wa.gov. DOH has the capability of converting the DVD to VHS if needed—please indicate your preference.

VACCINE ADVISORY COMMITTEE UPDATE

Recommendations for meningococcal vaccine, hepatitis A vaccine, and newer combination vaccines were unanimously adopted at the last meeting of the Washington State Vaccine Advisory Committee (VAC) on January 12, 2006.

The VAC adopted the Advisory Committee for Immunization Practice (ACIP) recommendations for meningococcal vaccine and hepatitis A vaccine. The VAC also updated its previous recommendation for newer combination vaccines to include consideration of ACIP recommendations, reasonableness, and safety and efficacy prior to the Department of Health making combination vaccines available to providers in the state.

The full text of the VAC recommendations are available by contacting Vicki M. Bouvier, Policy and Planning Coordinator, Immunization Program CHILD Profile, at 360-236-3483 or vicki.bouvier@doh.wa.gov.

The next VAC meeting is scheduled for April 27, 2006. The agenda and other VAC information is available on the Immunization Program CHILD Profile Web site at: http://www.doh.wa.gov/cfh/immunize/vacadvisorycomm.htm.

THIRD PARTY DISTRIBUTION IN WASHINGTON STATE, CONTINUED FROM PAGE 2

LHJs can monitor monthly provider vaccine use to help determine appropriate monthly orders for providers. Eventually, with LHJ approval, providers may be able to order through the Vaccine Ordering Module in the CHILD Profile Immunization Registry.

As monthly orders are entered in the system, provider order histories will also be available for reference. Providers will submit inventory-on-hand reports when they order, and LHJs can compare the inventory with monthly use prior to approving provider orders.

How will orders be managed during a vaccine shortage?
A system similar to what is currently in place will be applied during vaccine shortages to ensure equitable access to vaccines by all providers. This means that available vaccine will be divided between LHJs based on population.

How will vaccine accountability reports be handled?
Monthly accountability reports will still be sent to LHJs. Providers are encouraged to send them at the same time they order vaccine. LHJs should screen the reports for accuracy, timeliness, and completeness, and ensure that temperature logs are in place.

NATIONAL IMMUNIZATION CONFERENCE

The 40th National Immunization Conference took place March 6–9, 2006 in Atlanta, Georgia. More than 1500 people from around the United States and beyond attended the conference.

The conference had 15 plenary sessions and 72 workshops, covering all aspects of immunization, from adult immunization to immunization registries to health education.

Audio recordings and slides of conference presentations are now available at: http://www.cdc.gov/nip/nic/; if you were not able to attend, you can still benefit from the conference.

WORKING TOGETHER, CONTINUED FROM PAGE 1

requesting state funds in the 2007 legislative session for the rotavirus and human papiloma virus vaccines.

Washington's commitment to universal vaccines is inspiring and the pace at which new vaccines become recommended is challenging. With so many new vaccines becoming recommended recently, we are experiencing stress with the way our universal system works.

The time it takes for us to implement a new vaccine is problematic. We are beginning to explore ways to modify how our system works so that we could make new vaccines available earlier, while maintaining our state's strong commitment to universal vaccines.

The program is in a better position to meet these challenges since combining the Immunization Program with the CHILD Profile Program last summer. After a year's worth of discussion and analysis, we determined that there is enough commonality in our work to find significant efficiencies in integrating the two programs.

You'll see our new organizational structure in this newsletter. It is an exciting and thought provoking time. We are regularly identifying new and better ways of doing our work. I hope you are noticing and will also bare with us as we push forward in creating a program that will meet the current and future needs of the state.

Janna Bardi, Program Manager